

1240

N. B.—WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BUREAU OF VITAL STATISTICS				ARIZONA STATE BOARD OF HEALTH		STANDARD CERTIFICATE OF DEATH	
1. PLACE OF DEATH				County <u>Tulham</u> State <u>Arizona</u>		State File No. <u>115</u>	
District or Township <u>Primer</u>				City <u>Primer</u>		Registered No. <u>19</u>	
2. FULL NAME <u>David Larson Sanders</u>				(If death occurred in a hospital or institution, give its NAME instead of street and number).		Ward	
(a) Residence. No. <u>Schurst</u>				St. <u></u> Ward <u></u>		(If non-resident, give city or town and State)	
Length of residence in city or town where death occurred				yrs. <u>4</u> mos. <u>25</u> ds.		How long in U. S. if of foreign birth? yrs. mos. ds.	
PERSONAL AND STATISTICAL PARTICULARS							
3. SEX <u>male</u>	4. COLOR or RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED or DIVORCED. (Write the word) <u>single</u>					
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of <u>none</u>							
6. DATE OF BIRTH (month, day and year) <u>April 5, 1927</u>							
7. AGE	Years <u>0</u>	Months <u>11</u>	Days <u>25</u>	IF LESS than 1 day hrs. or min.			
8. OCCUPATION OF DECEASED							
(a) Trade, profession, or particular kind of work <u>none</u>							
(b) General nature of industry, business or establishment in which employed (or employer)							
(c) Name of employer							
9. BIRTHPLACE (city or town) <u>Schurst</u> (State or country)							
10. NAME OF FATHER <u>John Sanders</u>							
11. BIRTHPLACE OF FATHER <u>Porto Basso</u> (city or town) (State or country) <u>Arizona</u>							
12. MAIDEN NAME OF MOTHER <u>Emma Bell Bryant</u>							
13. BIRTHPLACE OF MOTHER <u>Bryce</u> (city or town) (State or country) <u>Arizona</u>							
14. Informant <u>John Sanders</u> (Address)							
15. Filed <u>9/8</u> 19 <u>27</u> <u>J. M. Hatcher</u> Registrar.							
MEDICAL CERTIFICATE OF DEATH							
16. DATE OF DEATH (month, day, and year) <u>8/30</u> 19 <u>27</u>							
17. I HEREBY CERTIFY, That I attended deceased from <u>8/24</u> 19 <u>27</u> to <u>8/30</u> 19 <u>27</u> , that I last saw him alive on <u>8/30</u> 19 <u>27</u> , and that death occurred, on the date stated above, at <u>3</u> <u>7</u> m. The CAUSE OF DEATH* was as follows: <u>General mination from</u> <u>shot wounds</u>							
(duration) yrs. mos. <u>35</u> ds.							
CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.							
18. Where was disease contracted <u>not at place of death?</u>							
Did an operation precede death? <u></u> Date of <u></u>							
Was there an autopsy? <u></u>							
What test confirmed diagnosis? <u>Albigen</u> (Signed) <u>8/31</u> 19 <u>27</u> (Address)							
* State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)							
19. PLACE OF BURIAL, CREMATION OR REMOVAL <u>Hubbard Cemetery</u>				DATE OF BURIAL <u>8/31/27</u>			
20. UNDERTAKER <u>Joe Sanders</u>				ADDRESS <u>Schurst</u>			